Prescription Drug Benefit Description

Herein called "Description"

Prescription Drug Program For State of Kansas Employees Health Plan

This booklet describes the Prescription Drug benefits available through the State of Kansas program. The prescription drug program is underwritten by the State of Kansas and administered by Caremark formerly known as AdvancePCS. The State of Kansas reserves the right to change or terminate the program at any time or to change the company that administers the program.

The Caremark Pharmacy and Therapeutics Committee administers the Preferred Drug List and assists the State in determining the appropriate tiers of coverage. Caremark is not the insurer of this Program and does not assume any financial risk or obligation with respect to claims.

Contact Information

For answers to any questions regarding
Your prescription claims payment contact:

Caremark
P.O. Box 52136
Phoenix, Az 85072-2136
1-800-294-6324

Table of Contents

Section 1 Definitions

Allowed Charge – the maximum amount the Plan determines is payable for a covered expense. For this Plan the Allowed Charge will be the contracted reimbursement rate including any applicable sales tax. When this Plan is secondary to other insurance coverage, the Allowed Charge will be the amount allowed but not covered by the other plan subject to the coverage provisions of this Plan.

Brand Name – Typically, this means a drug manufactured and marketed under a trademark, or name by a specific drug manufacturer. For purposes of pricing, drug classification (e.g., brand vs. generic) will be established by a nationally recognized drug pricing and classification source.

Compound Medication – a medication mixed for a specific patient and not available commercially. To be eligible for reimbursement a Compound Medication must contain at least one Legend Drug that has been assigned a national drug code (NDC) number, requiring a Physician's Order to dispense, and eligible for coverage under this Plan.

Coinsurance – is a sharing mechanism of the cost of health care and is expressed as a percentage of the Allowed Charge that will be paid by You and the balance paid by the Plan.

Copayment – a specified amount that You are required to pay for each quantity or supply of prescription medication that is purchased.

Copayment/Coinsurance Maximum – the maximum combined total for a Member on the Coinsurance and Copayments for Generic, Preferred and Special Case Medications. Coinsurance for Non Preferred Drug does not accumulate toward the Copayment/Coinsurance Maximum.

Drug Override – a feature that allows Members who meet specific criteria outlined in the Plan to receive Non Preferred Drugs at the Preferred Drug Coinsurance level. Your Coinsurance for Non Preferred Drugs with a Drug Override do not accumulate toward the Copayment /Coinsurance Maximum.

Experimental, Investigational, Educational or Unproven Services – medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan (at the time it makes a determination regarding coverage) to be: (1) not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopeia Dispensing Information as appropriate for the proposed use; or (2) subject to review and approval by any Institutional Review Board for the proposed use; or (3) the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or (5) for the primary purpose of providing training in the activities of daily living, instruction in scholastic skills such as reading or writing, or preparation for an occupation or treatment for learning disabilities.

Generic – Typically, this means a medication chemically equivalent to a Brand Name drug on which the patent has expired. For purposes of pricing, drug classification (e.g., Brand vs. Generic) will be established by a nationally-recognized drug pricing and classification source.

Legend Drug – medications or vitamins that by law require a physician's prescription in order to purchase them.

Lifestyle Medications – medications with primary indications for use of: weight loss; smoking cessation; infertility; erectile dysfunction; medications used primarily for cosmetic purposes; dental preparations (toothpaste, mouthwash, etc.); prescription medications where an equivalent product is available without a prescription; Drug Efficacy Study Implementation (DESI-5) medications – older medications which still require a prescription, but which the FDA has approved only on the basis of safety, not safety and effectiveness; Ostomy supplies.

Maximum Allowable Cost List (MAC List) – a list of specific multi-source Brand Name and Generic drug products that the maximum allowable costs have been established on the amount reimbursed to pharmacies.

Maximum Allowable Quantity List – some medications are limited in the amount allowed per fill. Limiting factors are FDA approval indications for (MAQ) as well as manufacture package size and standard units of therapy. The list is subject to periodic review and modification.

Medically Necessary – Prescription Drug Products which are determined by the Plan to be medically appropriate and: (1) dispensed pursuant to a Prescription Order or Refill; (2) necessary to meet the basic health needs of the Member; (3) consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies; and (4) commonly and customarily recognized as appropriate for treatment of the illness, injury, sickness or mental illness. The fact that a provider prescribed a Prescription Drug Product or the fact that it may be the only treatment for a particular illness, injury, sickness or mental illness does not mean that it is Medically Necessary. The fact that a medication may be medically necessary or appropriate does not mean that is a covered service.

Member – an individual eligible for benefits under the Plan as determined by the Plan Sponsor.

Non Preferred Drug – Any drug not listed on the Preferred Drug List or the Special Case Medication List of the Plan are considered Non Preferred.

Participating Pharmacy – a pharmacy that has entered into an agreement to provide Prescription Drug Products to Members and has agreed to accept specified reimbursement rates.

Pharmacy – a licensed provider authorized to prepare and dispense drugs and medicines. A Pharmacy must have a National Association of Boards of Pharmacy identification number (NABP number).

Plan – The benefits defined herein and administered on behalf of the State of Kansas by Caremark formerly known as AdvancePCS.

Plan Sponsor – State of Kansas

Preferred Drug List – a list that identifies those Prescription Drug Products that are preferred by the Plan for dispensing to Members when appropriate. This list is subject to periodic review and modification.

Preferred Drug– a drug listed on the Preferred Drug List.

Prescription Drug Product – a medication, product or device registered with and approved by the Food and Drug Administration (“FDA”) and dispensed under federal or state law only pursuant to a Prescription Order or Refill. For the purpose of coverage under the plan, this definition includes insulin and diabetic supplies: insulin syringes with needles, alcohol swabs, blood testing strips-glucose, urine testing strips-glucose, ketone testing strips and tablets, lancets and lancet devices.

Prescription Order or Refill – the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Prior Authorization – the process of obtaining pre-approval of coverage for certain Prescription Drug Products, prior to their dispensing, and using guidelines approved by the Plan Sponsor. The Plan retains the final discretionary authority regarding coverage.

Self-Injectable Drug –Injectable medications that are intended to be self-administered by the Member and/or a family member. Coverage is limited to those medications that have been designated by the Plan. This list is subject to periodic review and modification.

Special Case Medication – a group of high cost medications used for the treatment of catastrophic conditions. The list is subject to periodic review and modification.

Standard Unit of Therapy – a manufacturer’s pre-packaged quantity or an amount sufficient for one course of treatment at normal dosages.

You or Your – refers to the Member.

Section 2 Benefit Provisions

Coverage for Outpatient Prescription Drug Products

The plan provides coverage for Prescription Drug Products, if all of these conditions are met:

(1) it is Medically Necessary;
(2) it is obtained through a Participating Retail, Mail Order or Online Pharmacy or a Non Participating Retail Pharmacy;
(3) You are an eligible Member in the Plan; and
(4) the Prescription Drug Product is covered under the Plan and it is dispensed according to Plan guidelines.

Prescription Drug Benefits

Coverage Level	Prescription Drug Product	Member Responsibility
Tier One	**Generic Drugs**	**20% Coinsurance**
Tier Two	**Preferred Drugs**	**35% Coinsurance**
Tier Three	**Special Case Medications**	**$75 Copayment per unit**
Coinsurance/Copayment Maximum	**Tiers One, Tier Two and Tier Three Only**	**$2580 per person per year**
Tier Four	**Non Preferred and Compound Medications**	**60% Coinsurance**
Tier Five	**Lifestyle Medications**	**100% Coinsurance**

Benefits are provided for each eligible Prescription Drug Product filled, subject to payment of any applicable Coinsurance or Copayment. The Provider and the patient, not the Plan or the employer determine the course of treatment. Whether or not the Plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be. If You use a Participating Pharmacy, the Member's payment shall not exceed the Allowed Charge provided that You present Your identification card to the pharmacy as required. When a Non Participating Pharmacy is used, You will be responsible for the difference between the pharmacy's billed charge and Allowed Charge in addition to applicable Coinsurance or Copayment. Benefits for services received from a Retail Non Participating Pharmacy will be paid to the primary insured. You can not assign benefits under this program to any other person or entity.

***Generic Prescription Drug Products*:**
Your Coinsurance is 20% of the Allowed Charge.

***Preferred Brand Name Prescription Drug Products*:**
For eligible Preferred Brand Name Drugs, Your Coinsurance is 35% of the Allowed Charge. The Preferred Drug List is subject to periodic review and modification.

Non Preferred Brand Name Drug Products:
For eligible Non Preferred Brand Name Drug Products not included on the Preferred Drug List, Your Coinsurance is 60% of the Allowed Charge.

Special Case Medications:
The Copayment is $75 per standard unit of therapy not to exceed a 30-day supply of Prescription Drug Product. For quantities less than a thirty (30) day supply, Your responsibility is 25% Coinsurance of the Allowed Charge not to exceed $75.

Lifestyle Medications:
You will be responsible for 100% of the Allowed Charge.

Compound Medications:
The Coinsurance will be 60% of the Allowed Charge of the Compounded Medication.

Copayment/Coinsurance Maximum
The total Copayment/Coinsurance Maximum per year for Generic, Preferred or Special Case Medication is $2,580 per person. Non Preferred Drugs, even those being purchased with a Drug Override, do not accumulate toward the Copayment/Coinsurance Maximum. Purchases of Generic, Preferred and Special Medications in excess of the Member's Copayment/Coinsurance Maximum will be reimbursed at 100% of the Allowable Charge for the remainder of the calendar year.

Self-Injectable Medications
Coverage for Self-Injectable drugs under this Plan is limited to those medications that have been designated by the Plan Sponsor. A list of designated medications is available on the web at **https://khps.ks.gov** *(use the Caremark link on the provider page.)* This list is subject to periodic review and modification. The Self-Injectable treatment must be medically necessary and appropriate for the condition being treated. Some Self-Injectable Medications are available through SpecialtyRx.

SpecialtyRx
SpecialtyRx is a program that focuses on patients who utilize certain high cost Injectable medications. Eligible Members will be contacted directly by Caremark. This program offers Members a convenient source for these high cost injectable drugs, lower potential drug–to-drug interactions and improved therapy compliance. Members who elect to participate in the SpecialtyRX program will have access to pharmacist or nurses 24 hours a day, seven days a week. These clinicians specialize in the management of chronic conditions. Individualized care plans are developed for patient-specific conditions and involve You, Your physician, nurse, case manager, and clinical pharmacist in a coordinated and monitored course of treatment. Participation in the SpecialtyRx program is optional.

Initial Prescription Drug Product Purchase
Covered Prescription Drug Products are subject to the initial fill limit of thirty (30) consecutive day supply or one standard unit of therapy which ever is less.

A standard unit of therapy is up to a thirty (30) consecutive day supply of a Prescription Drug Product, unless adjusted based on the drug manufacture's packaging size or "standard units of therapy guidelines." Some products may be subject to additional supply limits adopted by the Plan.

Refill Guidelines
Refills for up to a sixty (**60) day supply** may be obtained at one time for most medications. The refill prescriptions must be filled within one hundred and twenty (120) days of the prior fill and must be for the same strength of Prescription Drug Product. If not filled within one hundred and twenty (120) days of the prior fill or if the drug strength changes, only a thirty (30) day supply will be allowed. Refills may be obtained on the following schedule:

Supply of Prescription Product	*Percentage Consumed*	Refill Available After
5 Day Supply	**40%**	**2 Days**
10 Day Supply	**60%**	**6 days**
21 Day Supply	**70%**	**15 Days**
30 Day Supply	**75%**	**22 Days**
60 Day Supply	**75%**	**45 Days**

Advance Purchases
Advance Purchase of Prescription Drug Products are available for active employees only who will be departing the U.S. for an extended period of time. Copayment and Coinsurance will be the applicable Participating Pharmacy payments are required for each thirty (30) day supply or standard unit of therapy received. Active employees may contact their Human Resource office to obtain the Advance Purchase Certificate. The completed

form must be signed by both the You and an agency employee with the authority to expend agency funds, and submitted to the Health Benefits Administration office **15 days in advance** of the anticipated departure date. Up to a one (1) year supply of medications may be obtained if the request is approved.

- When adequate time is not available to submit an Advance Purchase Request or purchases are made outside of the country the cardholder may submit the pharmacy receipts for reimbursement upon return from the extended absence. In order to be considered for reimbursement, the patient must have continuous coverage for the entire period of absence.

  For Prescription drugs purchased in the United States by the Member in excess of the supply limits of the plan may be covered once the time period covered by the excess supply has elapsed so long as the excess supply purchased does not overlap any other purchases for the same product. Claims must be filed within one (1) year and ninety (90) days of the date of purchase to Health Benefits Administration, 900 SW Jackson, Rm. 920-N, Topeka, Ks 66605.

  Prescription Drug Products purchased and used while outside the United States must include documentation of the purchase to include the original receipt that contains the patient's name, the name of the product, day supply and quantity purchased and price paid. An English translation and currency exchange rate for the date of service is required from You in order to process the claim. Only prescription drug that is eligible for payment under this Plan may be claimed for reimbursement. Claims must be filed within one (1) year and ninety (90) days of the date of purchase to Health Benefits Administration, 900 SW Jackson, Rm. 920-N, Topeka, Ks 66605.

Mail Order Pharmacy

Caremark offers a mail order service that may save You money on Your prescription drug services. The Mail Order Pharmacy is a convenient and cost effective way to obtain Your medication through the mail to any location in the United States. **The maximum supply available is a sixty (60) day supply.** All supply limits and plan requirements apply to mail order pharmacy purchases.

To order by mail, send the Mail Order Service Profile form (available at **https://khps.ks.gov** *use the Caremark link on the provider page* or by calling **1-800-294-6324**), and attach the original prescription from Your physician along with Your payment or credit card number to the address listed on the form.

If You have a new prescription and wish to start mail service right away, Caremark will call Your physician directly and enroll You in the FastStart program. Simply call FastStart toll free at **(866) 772-9503**. You must have Your prescription information as well as Your physician's telephone and FAX numbers for the representative. Caremark will call Your physician directly for Your prescription information and enroll You for mail service as soon as Your physician provides the necessary information.

New prescriptions and refills will typically arrive directly at Your home within 10-14 business days from the day You mail Your order. The mail order pharmacy is required by law to dispense the prescription in the exact quantity specified by the physician. Therefore, if the quantity prescribed is for less than plan maximums per fill, the mail order pharmacy will fill the exact quantity prescribed.

For refills:

The prescription label lists the date when You can request a refill and shows how many refills You have left. Refill prescriptions on the Internet by visiting **https://khps.ks.gov** *(use the Caremark link on the provider page.)* Have Your prescription number, date of birth and credit card information ready. You can also order refills by phone or through the mail. To use the automated phone service, call the toll-free number on the prescription label and have the prescription number, ZIP code and credit card information ready. Or, mail the refill slip and payment to **Caremark.com** in the envelope that was included with Your previous shipment.

Paper Claims

Members will need to file a paper claim for the following situations:

- **Anytime Prescription Drug Products are purchased from a Non-Participating Pharmacy.**

- If You do not present Your Identification Card at a Participating Pharmacy and are charged the retail cost

of the Prescription, You will be responsible for filing a paper claim for reimbursement. (The Caremark Help Desk **1-800-364-6331** can assist in transmitting a claim on-line if the Member does not have their Identification Card available.)

- If a Prescription Drug Product requires prior authorization and it has not been obtained, the Member may pay the full purchase price for the Product and submit a claim along with documentation for consideration of coverage under the Plan. Payment is not guaranteed by the Plan.

  Prescription drugs purchased by the Member in excess of the supply limits of the plan may be covered once the time period covered by the excess supply has elapsed so long as the excess supply purchased does not overlap any other purchases for the same product. Claims must be filed within one (1) year and ninety (90) days of the date of purchase to Health Benefits Administration, 900 SW Jackson, Rm. 920-N, Topeka, Ks 66605.

In any of these situations, You must pay full retail price at the pharmacy. A claim form should then be completed and sent (along with the original receipt and any additional information) to: **Caremark / P.O. Box 52136 /Phoenix, AZ 85072-2136**. Reimbursement to the Member for the cost of the prescription is limited to the Allowed Charge a Participating Pharmacy would have been paid, less applicable Coinsurance or Copayments. Claim forms can be found on the internet at https://kse.advancerx.com.

Time Limit for Filing Claims

You are responsible for making sure the Participating Pharmacy knows You have prescription drug coverage and submits a claim for You. Most claims under this program are submitted electronically at the time of purchase. For those claims that are not, electronic claims may be submitted or adjusted within thirty (30) days of purchase. If You use a Non Participating Provider, You must submit the notice yourself. Notice of Your claim must be given to the Plan within ninety (90) days after You receive services. If it is not reasonably possible for You to submit a claim within ninety (90) days after You receive services, You or someone authorized by You must submit the claim as soon as reasonably possible. No claim will be paid if not received by the Company within one (1) year and ninety (90) days after You receive services.

Section 3 Coordination of Benefits

Coordination of Benefits with Medicare as Primary

When Medicare is primary, the Plan will pay the balance of the Medicare Allowed Charge in full.

Coordination of Benefits with Commercial Insurance

Only prescription drug products covered under this Plan are eligible for payment. The Allowed Charge will be the amount allowed but not covered by the other plan. Payments are subject to this Plan's applicable Coinsurance, Copayments and Plan provisions and limitations.

Order of Benefit Determination

The plan that covers You as an active employee is primary to the plan that covers You as a dependent or retired employee, unless otherwise required by Medicare.

Determination of primary/secondary coverage for dependent children will be based upon the "birthday rule" unless otherwise required by court order or by law. The primary plan is the plan of the parent whose birthday is earlier (month and day) in the year.

If the parents are not married or separated (whether or not they were married) or are divorced, and the court decree does not allocate responsibility for health care or expenses, the order of benefit determination will be as follows:

a) The plan of the custodial parent;
b) The plan of the spouse of the custodial parent;
c) The plan of the noncustodial parent, and then
d) The plan of the spouse of the noncustodial parent.

Section 4 Prior Authorization

Certain Prescription Drug Products require Prior Authorization to be covered by the Plan. Prior Authorization is usually initiated by Your physician or pharmacist on Your behalf, however it remains Your responsibility. If these Prescription Drug Products are not authorized before being dispensed, You will be responsible for paying the full retail charge. In this case, You will need to submit a paper claim with supporting documentation to allow for consideration under the Plan. The Plan retains the final discretionary authority regarding coverage by the Plan.

The list of following medications require Prior Authorization to be covered. The list is subject to periodic review and modifications:

ADHD/Narcolepsy
- Adderall
- Desoxyn
- Dexedrine
- Dextrostat

Anemia
- Revlimid

Arthritis Agents
- Arava
- Enbrel
- Humira
- Kineret
- Orencia
- Remicade

Asthma
- Xolair

Diabetic
- Byetta
- Symlin

Growth Hormones
- Genotropin
- Geref
- Humatrope
- Norditropin
- Nutropin
- Nutropin AQ
- Nutropin depot
- Saizen
- Serostim
- Somavert
- Zorbtive

Migraine
- Amerge
- Frova
- Imitrex Nasal Spray
- Imitrex Tablet
- Imitrex Injection
- Maxalt
- Maxalt MLT
- Relpax
- Zomig
- Zomig Nasal Spray
- Zomig ZMT

MS Drugs
- Avonex
- Betaseron
- Copaxone
- Novantrone
- Rebif

Pain
- Stadol Nasal Spray

Psoriasis
- Raptiva

Tretinoin Products
- Altinac
- Avita
- Retin-A
- Retin-A Micro
- Tretinoin

Section 5 Drug Override

If You are taking a Non Preferred Drug and can show that You tried at least **two (2)** different Preferred Drugs in the same therapeutic class, Your physician may call the Caremark Prior Authorization Department at 1-800-294-5979 (for physician use only) to request a drug override. Approvals will be granted in the following situations:

1) The patient has used at least two (2) Preferred Drugs

and

a) The Preferred Drugs were ineffective for the patient, or
b) The patient could not tolerate the Preferred Drugs

or

2) The patient meets other pre-established clinical criteria approved by the Plan Sponsor.

If the request is approved, an override will be entered to allow the Non Preferred Drug to be paid for at the Preferred Drug Coinsurance. Because these are still Non Preferred Drugs, the Coinsurance does not apply toward the Coinsurance/Copayment maximum.

Section 6 Fraudulent, Inappropriate Use or Misrepresentation

You and Your dependent(s) coverage may be terminated and other appropriate action taken as determined by the Plan Sponsor, if You or Your dependents participate in any act that constitutes fraud, gross misbehavior, misrepresentation or omission of pertinent facts in applying for or seeking benefits under the Plan. This shall also include other improper action as determined by the Plan Sponsor. This includes but is not limited to:

a. Misrepresent or omission of material facts to obtain coverage or allowing unauthorized persons use of Your State of Kansas Drug Plan identification card to obtain services, supplies or medication that are not prescribed or ordered for You or a covered family member or for which You are not otherwise entitled to receive. In this instance, Coverage for You and/or any covered dependent(s) may be terminated by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.

b. Permitting the unauthorized use of Your State of Kansas Drug Plan identification card to obtain medication, services or supplies for someone not covered under Your State of Kansas Prescription Drug membership. In this instance, Coverage of the member and/or dependent(s) may be terminated by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.

c. Using another State of Kansas member's Prescription Drug Plan identification card to obtain medication, services or supplies for Your or some other third party not specifically covered under that membership may result in the termination of your coverage and that of your dependents by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.

Section 7 Exclusions

The plan does not cover the following:

1. Prescription Drug Products in amounts exceeding the supply limit referenced in Section 2.
2. Drugs which are prescribed, dispensed or intended for use while You are an inpatient in a hospital or other facility.
3. Experimental, Investigational, Educational or Unproven Services, technologies which include medical, surgical, diagnostic, psychiatric, substance abuse, or other health care, supplies, treatments, procedures, drug therapies or devices.
4. Prescription Drug Products furnished to a Member by any local, state or federal government entity; except as otherwise provided by law, any Prescription Drug Product to the extent payment or benefits are provided or available from any local, state or federal government entity (for example, Medicare) regardless of whether payment or benefits are received.
5. Prescription Drug Products for any condition, illness, injury, sickness or mental illness arising out of or in the course of employment for which compensation benefits are available under any Worker's Compensation Law or other similar laws, regardless of whether the Member makes a claim for, or receives such compensation or benefits.
6. Compounded drugs not containing at least one (1) ingredient with a valid National Drug Code (NDC) number and requiring a Physician's Order to dispense. In addition, the Compounded Medication must have FDA approval.
7. Drugs available over-the-counter or for which the active ingredients do not require a Prescription by federal or state law.
8. Injectable drugs administered by a Health Professional in an inpatient or outpatient setting.
9. Durable or disposable medical equipment or supplies, other than the specified diabetic and ostomy supplies.
10. Replacement Prescription Drug Products resulting from lost, stolen or spilled Prescription Orders or Refills.
11. Legend general vitamins except Legend prenatal vitamins, Legend vitamins with fluoride, and Legend single entity vitamins.
12. Prescription Drug Products that are not medically necessary.
13. Charges to administer or inject any drug.
14. Prescription Drug Products that are administered or entirely used up at the time and place ordered, such as in a clinic or physician's office.

15. Prescription Drug Products for which there is normally no charge in professional practice.
16. Contraceptive devices, therapeutic devices, artificial appliances, or similar devices, regardless of intended use.
17. Prescription Drug Products purchased from an institutional pharmacy for use while the Member is an inpatient in that institution.
18. Charges for the delivery of any drugs.
19. Prescription Drug Products obtained for use in connection with the treatment of drug addiction.
20. Prescription Drug Products approved for experimental use only.
21. The Plan has the right to deny benefits for any drug prescribed or dispensed in a manner that does not agree with normal medical or pharmaceutical practice.
22. Benefits are not available to the extent a Prescription Drug Product has been covered under another contract, certificate or rider issued by the Plan Sponsor.
23. Coverage for allergy antigens under any circumstances.
24. Enteral nutritional supplements which do not qualify as a Prescription Drug Product as defined herein.